AVE MARIA UNIVERSITY

Employee Direct Deposit Authorization Agreement
Health Savings Account

I hereby authorize my employer, Ave Maria University, to withhold a biweekly pre-tax Health Savings Account deduction from my biweekly payroll check and deposit to the financial institution (hereinafter BANK) indicated below. Further, I authorize BANK to accept and to credit any credit entries indicated by AMU to my account. In the event that AMU deposits funds erroneously into my account, I authorize AMU to debit my account for an amount not to exceed the original amount of the erroneous credit.

Employee Information:

Employee Name (Please print): _____

Employee Social Security Number: _____-_____-_____

Type of Request (Please check as applicable and indicate effective date as requested):

_____ Begin Deposit effective___/____/____

_____ Change Information effective___/____/____

_____ Cancel Deposit effective___/____/____

_____ Single High Ded. Health Plan Coverage _____Family High Ded. Health Plan Coverage

Bank Name: _____

Health Savings Account Number: _____

Bank Routing Number: _____

(Attach a voided check or deposit slip.)

I wish to deposit: $_____.00 per pay period into my Health Savings Account.

Note: For 2015, not to exceed $3350 annually for single, or $6650 annually for family.
For 2016, not to exceed $6,750 for Family coverage

(If you are age 55 or older, you can contribute up to $1,000 more than the limits listed here as a catch-up contribution.)

This authorization is to remain in full force and effect until AVE MARIA UNIV. and BANK have received written notice from me of its termination in such time and in such manner as to afford AVE MARIA UNIVERSITY and BANK a reasonable opportunity to act on it.

Employee Signature: _____ Date:___/____/____